FORMS FOR THE FUTURE
CTBCP Annual Meeting
March 20, 2014

Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
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CDC – PHAP Associate
IDB - Office of the Director

MISSION AND VISION

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

FOCUS

- Latent Tuberculosis Infection (LTBI)
- Project Preparation
- Verify service delivery
- Develop assessment /audit tools
- Forms

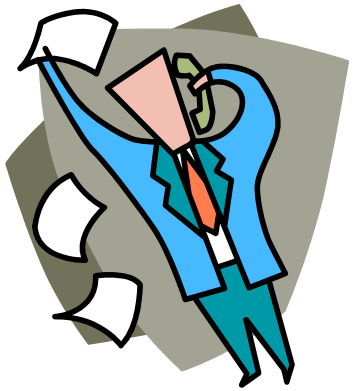
Latent Tuberculosis Infection (LTBI)

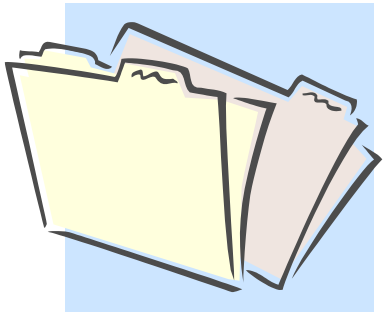
- Purpose of project
  - Create and develop an Audit Tool (AT) to regulate the quality of LTBI case services at a Federally Qualified Health Center (FQHC)

- Background
  - The Baltimore City Health Department (BCHD) TB Division implemented outsourcing LTBI case services to a local FQHC
    - **Baltimore Medical Systems** (BMS)- Highland Town Location
    - Serves 22,000 people
    - Delivers 84,000 medical visits annually

Project Preparation

- **Research**
  - Data Collection
  - Relationship dynamics
  - Responsibilities and expectations





Verify Service Delivery

Baltimore City Health Department

and

Baltimore Medical Systems

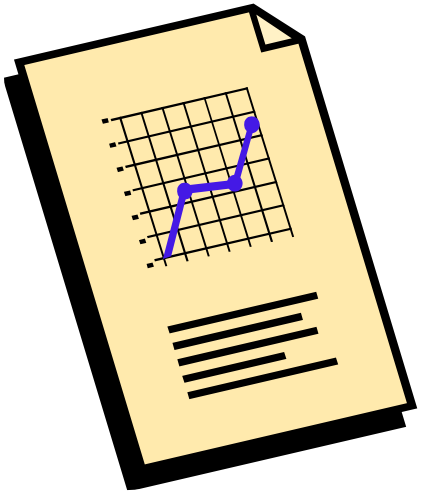
- Analyze organizational structures
- Review policies and procedures
- Compare variation of provided services
- Evaluate current practices

Develop assessment /audit tools

- Create assessment and audit tool
- Include the following variables:
  - Population Risk
  - Medical Risk & History
  - Current Medications
  - HIV Testing Information
  - Treatment Plans
  - Treatment Outcomes

Forms

- Design
- Data
- Delivery
- Document
- Discuss



FEEDBACK

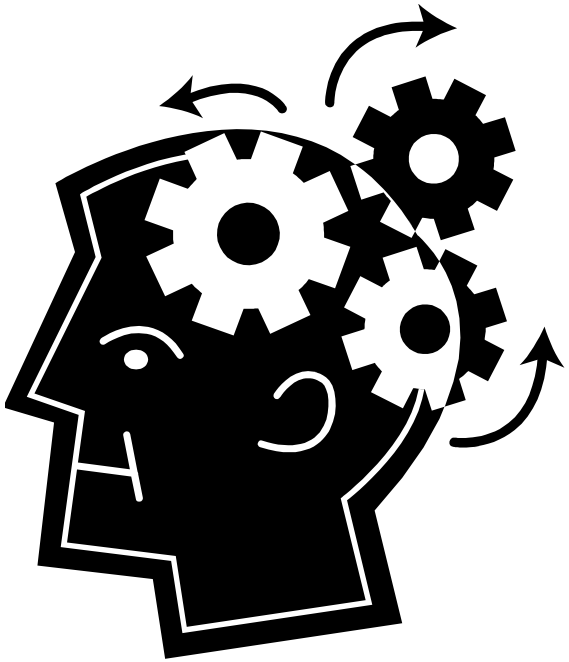
- Information Gathering:
  - Center for Tuberculosis Control and Prevention
  - Baltimore City Health Department
- Content Parameters
- Document Review
- Comparison and Consensus:
  - Center for Tuberculosis Control and Prevention
  - Baltimore City Health Department
  - Baltimore Medical Systems

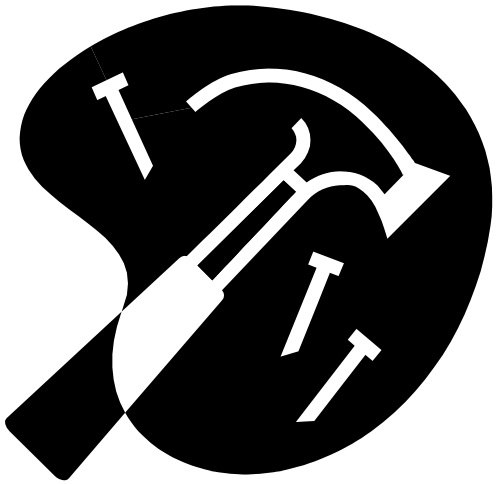
REGULATE QUALITY OF CARE

- Access to data
- Perform audit on electronic medical records
- Verify quality of medical services
- Identify discrepancies
- Propose and implement Corrective Action Plans (CAP)

FROM IMAGINATION TO IMPLEMENTATION

- Risk Assessment Form (RAF)
- BMS Assessment Tool- Treatment Record
- Audit Tool (AT)





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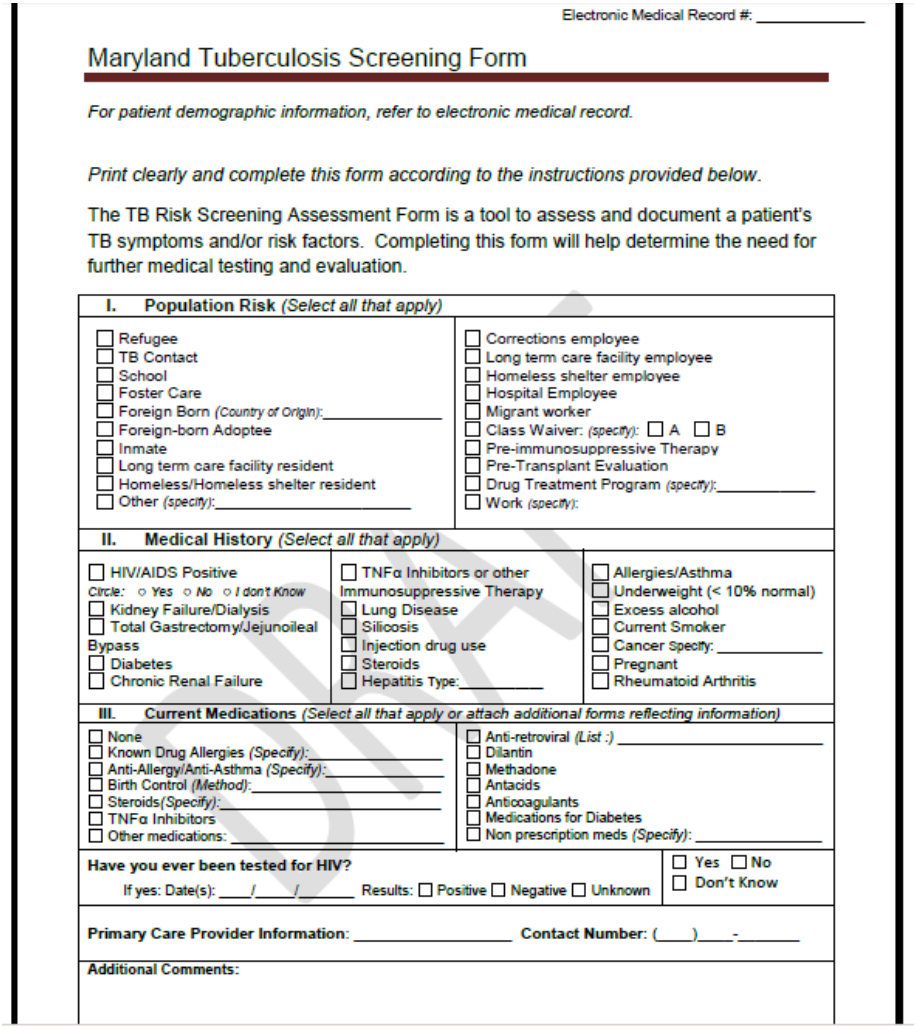
Risk Assessment



Electronic Medical Record #: _____

Maryland Tuberculosis Screening Form

For patient demographic information, refer to electronic medical record.

Print clearly and complete this form according to the instructions provided below.

The TB Risk Screening Assessment Form is a tool to assess and document a patient's TB symptoms and/or risk factors. Completing this form will help determine the need for further medical testing and evaluation.

I. Population Risk *(Select all that apply)*

- ☐ Refugee
- ☐ TB Contact
- ☐ School
- ☐ Foster Care
- ☐ Foreign Born *(Country of Origin)*:_____
- ☐ Foreign-born Adoptee
- ☐ Inmate
- ☐ Long term care facility resident
- ☐ Homeless/Homeless shelter resident
- ☐ Other *(specify)*:_____
- ☐ Corrections employee
- ☐ Long term care facility employee
- ☐ Homeless shelter employee
- ☐ Hospital Employee
- ☐ Migrant worker
- ☐ Class Waiver: *(specify)*: ☐ A ☐ B
- ☐ Pre-immunosuppressive Therapy
- ☐ Pre-Transplant Evaluation
- ☐ Drug Treatment Program *(specify)*:_____
- ☐ Work *(specify)*:

II. Medical History *(Select all that apply)*

- ☐ HIV/AIDS Positive
  Circle: ○ Yes ○ No ○ I don't Know
- ☐ Kidney Failure/Dialysis
- ☐ Total Gastrectomy/Jejunoileal Bypass
- ☐ Diabetes
- ☐ Chronic Renal Failure
- ☐ TNFα Inhibitors or other Immunosuppressive Therapy
- ☐ Lung Disease
- ☐ Silicosis
- ☐ Injection drug use
- ☐ Steroids
- ☐ Hepatitis Type:_____
- ☐ Allergies/Asthma
- ☐ Underweight (< 10% normal)
- ☐ Excess alcohol
- ☐ Current Smoker
- ☐ Cancer Specify: _____
- ☐ Pregnant
- ☐ Rheumatoid Arthritis

III. Current Medications *(Select all that apply or attach additional forms reflecting information)*

- ☐ None
- ☐ Known Drug Allergies *(Specify)*:_____
- ☐ Anti-Allergy/Anti-Asthma *(Specify)*:_____
- ☐ Birth Control *(Method)*:_____
- ☐ Steroids *(Specify)*:_____
- ☐ TNFα Inhibitors
- ☐ Other medications: _____
- ☐ Anti-retroviral *(List :)* _____
- ☐ Dilantin
- ☐ Methadone
- ☐ Antacids
- ☐ Anticoagulants
- ☐ Medications for Diabetes
- ☐ Non prescription meds *(Specify)*: _____

Have you ever been tested for HIV? ☐ Yes ☐ No ☐ Don't Know

If yes: Date(s): ____/____/_____ Results: ☐ Positive ☐ Negative ☐ Unknown

Primary Care Provider Information: _____ **Contact Number**: (____)____-_____

Additional Comments:

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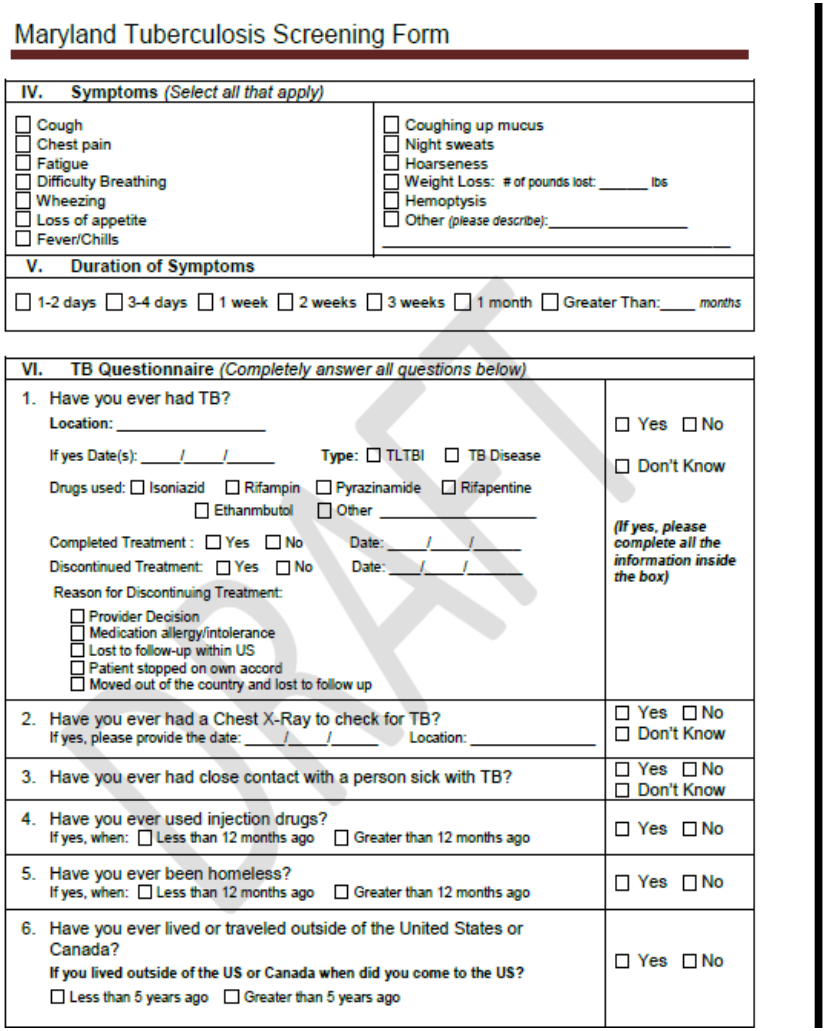

Maryland Tuberculosis Screening Form

IV. Symptoms *(Select all that apply)*

- ☐ Cough
- ☐ Chest pain
- ☐ Fatigue
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Loss of appetite
- ☐ Fever/Chills
- ☐ Coughing up mucus
- ☐ Night sweats
- ☐ Hoarseness
- ☐ Weight Loss: # of pounds lost: _____ lbs
- ☐ Hemoptysis
- ☐ Other *(please describe)*:_____

V. Duration of Symptoms

☐ 1-2 days ☐ 3-4 days ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 1 month ☐ Greater Than:____ *months*

VI. TB Questionnaire *(Completely answer all questions below)*

1. Have you ever had TB? ☐ Yes ☐ No ☐ Don't Know
   Location: _____
   If yes Date(s): ____/____/_____ **Type:** ☐ TLTBI ☐ TB Disease
   Drugs used: ☐ Isoniazid ☐ Rifampin ☐ Pyrazinamide ☐ Rifapentine ☐ Ethanmbutol ☐ Other _____
   Completed Treatment : ☐ Yes ☐ No Date: ____/____/_____
   Discontinued Treatment: ☐ Yes ☐ No Date: ____/____/_____
   Reason for Discontinuing Treatment:
   - ☐ Provider Decision
   - ☐ Medication allergy/intolerance
   - ☐ Lost to follow-up within US
   - ☐ Patient stopped on own accord
   - ☐ Moved out of the country and lost to follow up

   (If yes, please complete all the information inside the box)
2. Have you ever had a Chest X-Ray to check for TB? ☐ Yes ☐ No ☐ Don't Know
   If yes, please provide the date: ____/____/_____ Location: _____
3. Have you ever had close contact with a person sick with TB? ☐ Yes ☐ No ☐ Don't Know
4. Have you ever used injection drugs? ☐ Yes ☐ No
   If yes, when: ☐ Less than 12 months ago ☐ Greater than 12 months ago
5. Have you ever been homeless? ☐ Yes ☐ No
   If yes, when: ☐ Less than 12 months ago ☐ Greater than 12 months ago
6. Have you ever lived or traveled outside of the United States or Canada? ☐ Yes ☐ No
   If you lived outside of the US or Canada when did you come to the US?
   ☐ Less than 5 years ago ☐ Greater than 5 years ago

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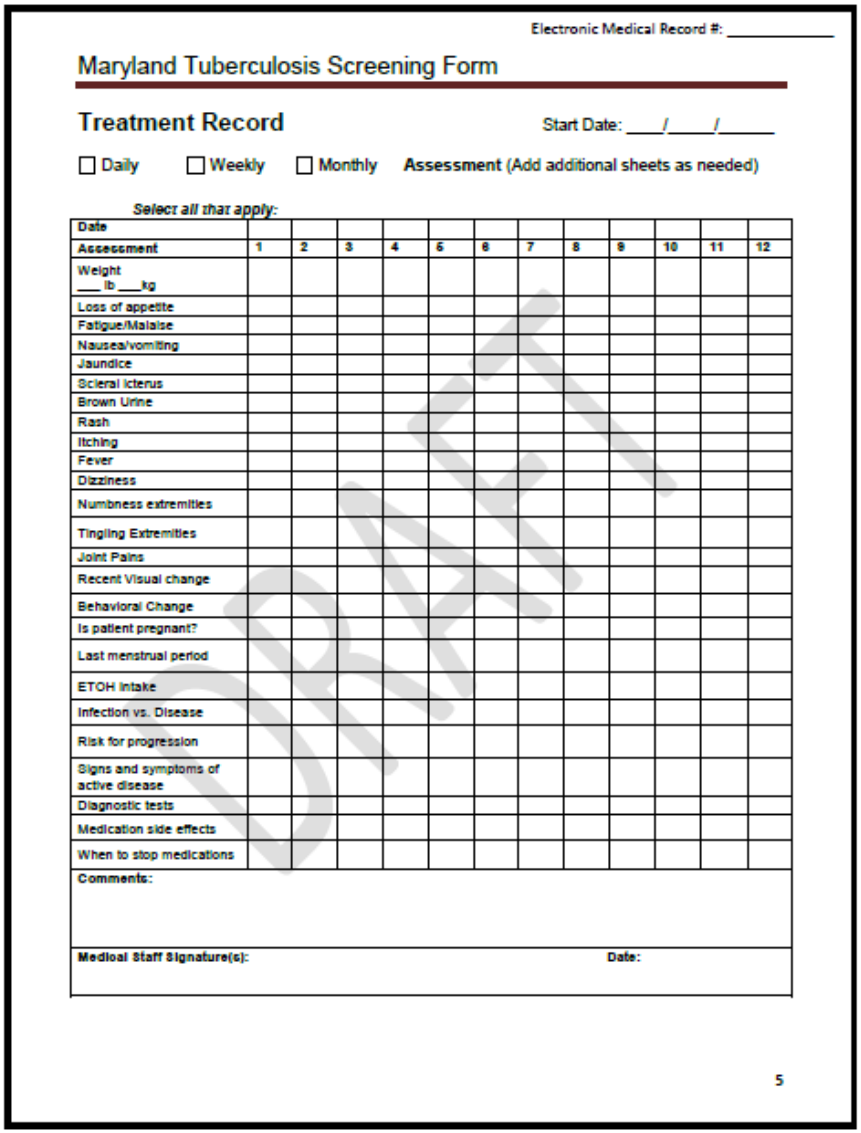
Treatment Record

-Utilized by the FQHC clinician staff to track and monitor monthly treatment progress of LTBI cases



Electronic Medical Record #: _____

Maryland Tuberculosis Screening Form

Treatment Record Start Date: ___/___/_____

☐ Daily ☐ Weekly ☐ Monthly **Assessment** (Add additional sheets as needed)

Select all that apply:

Date												
Assessment	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Weight ___lb ___kg												
Loss of appetite												
Fatigue/Malaise												
Nausea/vomiting												
Jaundice												
Scleral icterus												
Brown Urine												
Rash												
Itching												
Fever												
Dizziness												
Numbness extremities												
Tingling Extremities												
Joint Pains												
Recent Visual change												
Behavioral Change												
Is patient pregnant?												
Last menstrual period												
ETOH intake												
Infection vs. Disease												
Risk for progression												
Signs and symptoms of active disease												
Diagnostic tests												
Medication side effects												
When to stop medications												
Comments:												
Medical Staff Signature(s): **Date:**												

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Audit Tool (AT)

TB Audit Review Tool

Directions: To effectively utilize the audit review tool, place a **Y** in the fields that apply to each measure, an **N** in the fields that do not apply to each measure, and an **NA** in the fields that are not applicable to each measure under the medical record reviewed.

Instructions: At least 8 records from the same staff should be reviewed using this audit tool. Any issue's identified should be addressed with a corrective action form attached on page 2.	***Electronic Medical Record Numbers***							
Demographic information completely documented								
Language barriers identified								
If Foreign-Born, country of origin documented								
If applicable, Class A or B Waiver Identified								
Population risk documented								
Medical history documented								
TB symptoms documented								
Duration of symptoms documented								
Previous history of TB documented								
Risk of TB exposure documented								
Use of injection drug use documented								
Homeless status documented								
Living and/or travel outside U.S. documented								
Immunosuppressant treatment documented								
HIV status, testing, and results documented								
Current medications, allergies, and pre-existing conditions that may indicate adverse events from LTBI medication documented								
Skin Test result documented in mm								
IGRA Test result documented								
Chest x-ray result provided								
Sputum sample results documented								
Substance abuse behaviors identified								
Treatment plan for TB Infection documented								
Education provided to client on symptoms and side effects of prescribed medications								
Monthly assessment for adverse reactions and medication compliance								
Appropriate management of treatment interruptions documented								
Direct observation of LTBI treatment documented								
TB treatment outcome documented								
Referrals to local health department documented								
Completion of adequate regimen within 12 months documented								

Directions: After completing the audit review of medical records by staff member, evaluate and identify findings highlighted on the audit tool listed as **N** in the fields and develop a corrective action plan to address the issue.

Staff Name	

Corrective Action Plan		
Electronic Medical Record Number	**Findings**	**Corrective Action Plan**
Additional Comments:		

Staff Signature: _____ Date___/___/___

Audit Reviewer Signature: _____ Date___/___/___

FUTURE

Next Steps

- Implementation of tools
- Quarterly audits
- Track effectiveness
- Evaluate efficiency

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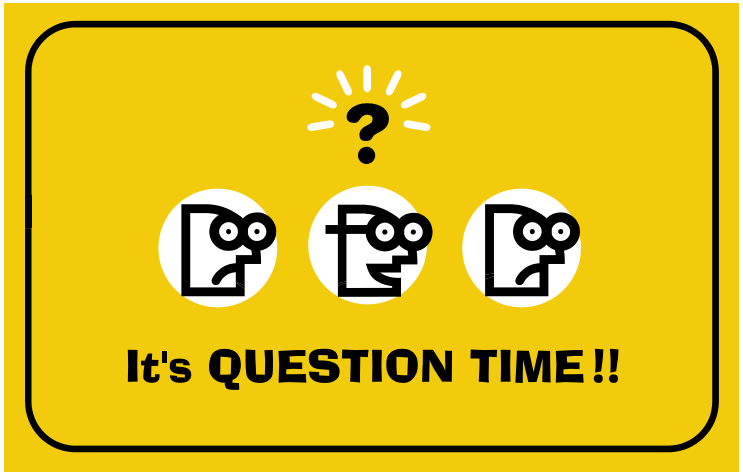
QUESTIONS



Prevention and Health Promotion Administration

http://phpa.dhmh.maryland.gov